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ABSTRACT

The study reports on a comparative analysis of behavior disorder definitions and eligibility criteria for special education cooperatives (N=90) in the state of Illinois. Data regarding entrance and exit criteria and referral, evaluation and program placement procedures are evaluated. Among results were that 35% of respondents reported that no guidelines for the identification of behavior disorders in children were in use; that 24% used the Illinois definition; that though 84% reported entrance criteria for programs, only 29% used established program exit criteria. Typical entrance criteria included duration of the behavior and documentation of unsuccessful intervention attempts. Program implications are reviewed and the need for definitional and diagnostic consensus is discussed. (Author/DB)

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Diagnosing Behavior Disorders: An Analysis of Illinois Criteria

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Abstract

This study reports a comparative analysis of behavior disorders definitions and eligibility criteria for special education cooperatives (N=90) in the State of Illinois. Data regarding entrance and exit criteria and referral, evaluation and program placement procedures are evaluated. Program implications are reviewed and the need for definitional and diagnostic consensus is discussed.

Because a category called behavior disorders exists in special education, and also because many children are assessed, labeled and placed in classes for children with behavior disorders, popular wisdom suggests that fairly well defined diagnostic criteria and systematic procedures exist for identifying children with behavior disorders. In a recent paper (Swartz, Mundschenk, and Mosley, in press) problems associated with the diagnosis of mental retardation in Illinois were examined and discussed. Although the M.R. definition is objective and enjoys general acceptance in the field, diagnostic procedures and performance criteria for applying the M.R. definition show great variation in Illinois and presumably, nationally.

If this is the case with a categorical area of special education where definitional consensus exists, it is also to be expected in a categorical area of special education such as behavior disorders where little or no definitional consensus exists.

The lack of definitional agreement probably relates to the fact that the B.D. definition, unlike the M.R. definition, places greater reliance on subjectivity and professional judgment. McGinnis, Kiraly & Smith (1984) have noted that diagnosis of behavior disorders is strongly influenced by the medical model approach which involves strong reliance on clinical judgment in the process of identifying behavior disorders in children.

Interestingly enough, it is school psychologists who play a primary role in identifying children with behavior problems, and whose role has increased under P.L. 94-142 (Mowder, 1980). Yet school psychologists have

been reported to experience difficulty assessing children for behavior disorders (Gresham, 1982, 1985). Ramage (1979) and Prout (1983) report that school psychologists lack the necessary knowledge, skills and training to assess children for behavior disorders.

Whether or not psychologists are able to competently identify students with behavior disorders, the basic problem of diagnosing behavior disorders in children in the public schools appears to begin with and to be centered in the definition or definitions of behavior disorders. Grosenick and Huntze (1980) regard B.D. as one of the most ambigious categorical areas of special education. In surveying all the states and the District of Columbia, Epstein, Cullinan, and Sabatino (1977) and Cullinan and Epstein (1979) found no agreement on definitions of B.D. and no consensus on identification criteria across the states. This same point regarding lack of definitional agreement has been made by others (Balow, 1979; Forness, Sinclair & Russell, 1984).

From the literature reviewed it is clear that a number of studies indicate that the area of behavior disorders is difficult to define (Grosenick & Huntze, 1980), that the field itself lacks definitional consensus (Balow, 1979; Forness, Sinclair & Russell, 1984), and that when state definitions of B.D. are compared nationally, no consensus exists with regard to definitions of B.D. or to criteria used to identify students as B.D. (Epstein, Cullinan & Sabatino, 1977; Cullinan & Epstein, 1979; Kavale, Forness & Alper, 1986). Smith (1985) has pointed out that federal and

state education agencies are responsible for monitoring procedures for identifying and appropriately serving children with behavior disorders. Although P.L. 94-142 presents the federal definition (seriously emotionally disturbed), a number of differing definitions are used at the state level (Epstein, Cullinan & Sabatino, 1977). Some of these definitions include the P.L. 94-142 definition, some exclude it (Kavale, Forness & Alper, 1986). Perhaps one reason for such broad definitional divergence lies in the fact that the federal agency does not require states to use the P.L. 94-142 definition of seriously emotionally disturbed. The only requirement is that the definition used by a state be capable of equivalently identifying children in the parallel category. The Illinois B.D. definition pre-dates the passage of federal legislation and no conversion efforts or attempts to reconcile the differences have been undertaken.

This study was undertaken to determine whether the B.D. definitional ambiquity, confusion, and lack of consensus which has been shown to exist across states nationally, also exists within a single state. To examine this question letters were sent to all Illinois special education cooperatives requesting copies of written criteria used in identifying children with behavior disorders for the purposes of comparative analysis.

Method

Directors of special education (N=90) of all special education cooperative organizations in Illinois were surveyed regarding diagnostic criteria and identification procedures for children with behavior disorders. Special education cooperative organizations were chosen as the source of data because they provide administrative oversight of special education programs for the more than 1000 local school districts in the State of Illinois. Seventy-five responses (83 percent response rate) were obtained and written criteria and procedures were received from all organizations reporting that guidelines had been developed and were presently in use.

Results

Twenty-six, 35 percent, of the respondents reported that no guidelines for the identification of behavior disorders in children were in use in their cooperative and constituent districts. Of those using written criteria, guidelines ranged from one page elaborations of the state definition for behavior disorders (The child exhibits an affective disorder and/or adaptive behavior which significantly interferes with his or her learning and/or social functioning, Illinois State Board of Education, 1979) to extensive documents that identified entrance and exit criteria, prescribed diagnostic criteria and recommended service delivery options and instructional strategies.

Table 1 summarizes the major provisions of the behavior disorders guidelines available for analysis.

Table 1

Guidelines Used to Identify Behavior Disorders in Illinois Special Education Cooperatives

	frequency	%
No identification guidelines used	26	35
Written guidelines developed and used	49	65
Definitions		
Illinois statutory definition	12	24
Modification of Illinois definition	9	18
Locally developed definition	17	35
Severely emotionally disturbed (94-142)	2	4
Other definition	3	6
No definition	6	12
Eligibility		
entrance criteria	41	84
exit criteria	14	29
no criteria	5	10
Procedures		
referral	30	61
assessment and evaluation	23	47
program placement	12	24
no procedures	6	12

Most identification guidelines specified a behavior disorder definition as a beginning point in the diagnostic process. Twenty-one cooperatives used the Illinois definition (24 percent) or some modification of the Illinois definition (18 percent). Of the nine respondents using a modification of the Illinois definition, six added behaviors that disrupted the learning of others to the behavior disorders category.

Seventeen respondents, 35 percent, reported the use of a behavior disorders definition developed locally by special education teachers and other special services personnel. Table 2 summarizes the common elements of locally developed definitions. The three most frequent elements of locally developed definitions were that the behavior disorder impedes the student's learning, 88 percent; affects social relations, 65 percent; and the necessity of behaviors that were of excessive freqüency, duration, and intensity, also 65 percent. Other elements of the definitions include; impede learning of others, 47 percent; failure of remediation attempts, 41 percent; behaviors must occur in the school setting, 35 percent; truancy and student's learning not necessarily impeded, both 12 percent. Behavior disorders caused by other handicapping conditions and cultural factors were specifically excluded, 35 percent and 29 percent respectively. Children who are truant or involved in substance abuse were also excluded, both 24 percent.

Table 2

Common Elements of Locally Developed Definitions
(N=17)

Specifically Included	frequency	%
impede student's learning	15	88
affect social relations	11	65
frequency, duration, intensity of behaviors	11	65
impede learning of others	8	47
failure of remediation attempts	7	41
occur in school setting	6	35
truancy	2	12
student's learning not necessarily impeded	2	12
Specifically Excluded		
caused by other conditions	6	35
caused by cultural factors	5	29
truancy	4	24
substance abuse	4	24

Only two cooperatives reported the use of the severely emotionally disturbed definition included in Public Law 94-142 (Federal Register, 1977). Three districts reported the use of a behavior disorders definition developed by others; 2 used Bower's (1969), and 1 used Kirk's (1972), and 6 reported no definition of the category.

The large majority of respondents, 84 percent, reported entrance criteria for behavior disorders programs. Only approximately one-third, 29 percent used established program exit criteria. Five organizations, 10

percent, use neither entrance nor exit criteria. Table 3 summarizes the criteria established by those respondents who have developed entrance/exit criteria.

Table 3

Criteria for Program Entrance and Exit

Entrance criteria (N=41)	frequency	%
duration of behavior	27	66
intervention documentation	25	61
specified behaviors	25	61
ability/performance discrepancy	14	34
functioning inability in regular class	11	27
pervasive behaviors	11	27
test results	6	15
truancy	3	7
Exit criteria (N=14)		
sustained progress	9	64
success in regular class	9	64
reduced behavior incidents	7	50
test results	4	29

Approximately two-thirds of those using entrance criteria reported that the duration of the behavior(s), 66 percent, documentation that unsuccessful intervention attempts had been made and a listing of specific qualifying behaviors, both 61 percent, were used in decision making. Other criteria used included; ability/performance discrepancy, 34 percent; the inability to function in a regular classroom, 27 percent; behaviors were

pervasive, in that they occurred in a variety of settings, also 27 percent; test results, 15 percent; and truancy, 7 percent.

Exit criteria were established by relatively few organizations (14) and were much less specific than entrance criteria. Criteria used included sustained progress in the special program, successful performance in a regular classroom, both 64 percent, reduced number of incidents of problem behaviors, 50 percent, and test results, 29 percent.

Thirty-four organizations provided procedural guidelines for the referral, evaluation and placement of behavior disordered children. Table 4 summarizes the various procedures employed.

Table 4

Referral, Evaluation and Placement Procedures
(N=34)

Referral	frequency	%
prior intervention	16	47
regular teacher report	10	29
conference	2	6
administrative approval	2	6
Evaluation		
case study	25	74
record of observed behaviors	23	68
standardized tests	6	18
psychiatric evaluation	4	12
personality and projective tests	4	12
Program Placement		
multidisciplinary staffing	21	62
program objectives	14	41
specified committee members	7	21
severity	5	15

Sixteen respondents (47 percent) required documentation of prior intervention attempts as a condition of referral. Two required a pre-referral conference and two required administrative approval for referral, both 6 percent. Ten (29 percent) required regular teachers to refer and document with anecdotal or observed behavior reports.

The majority of respondents (74 percent) required completion of the case study required by state regulations (Illinois State Board of Education, 1979) as part of their evaluation process. Twenty-three (68 percent) used a record of observed behaviors. Additional evaluation procedures included; the use of standardized tests, 18 percent, personality and projective tests, and a psychiatric evaluation, all 12 percent.

Program placement decisions were made during a multidisciplinary staffing by 62 percent of the respondents. Seven (21 percent) specified members of the staffing team. Program objectives were used in the placement process by 41 percent and severity of the behavior disorder by 15 percent.

Discussion

That considerable variation exists in the definition of behavior disorders and the criteria used to identify children with behavior disorders is abundantly clear. Though a specific definition is prescribed by state statute and administrative rules, it is clear that these do not enjoy broad support or use. The conceptual and procedural differences are clearly illustrated by how the disorder is defined, what criteria are used to identify children who are behavior disordered, and the procedures used to refer, evaluate and provide services.

The literature confirms that there is no definitional consensus nationally in the field of behavior disorders. Illinois is no exception. There is little debate that a significant number of children experience difficulties in learning because of emotional problems. It is, however, arguable that the federally defined category, severely emotionally disturbed, and the Illinois category are conceptually or in practice the same. The implementation problems identified in the literature are also evidenced in Illinois.

Approximately one-half of the cooperatives in Illinois are using the state behavior disorders definition or some locally initiated modification of the definition. To a great extent, the high percentage of groups who have developed their own definition locally, speaks to the confidence in this definition and the perception that it clearly delineates the category of children to be served. Most of the modified versions and the locally

developed definitions attempt to correct the possibility of including a child in this category when the disorder affects social functioning rather than learning. In other words they are delimiting the disorder not only to those that impact learning, which is probably appropriate, but also to those that occur in a school setting which might not be appropriate.

Many of the locally developed definitions seem to be school centered rather than child centered. Much is made of the expected impact of this disorder in the school setting and on the schooling process. Such an approach in developing diagnostic criteria is fully expected, the same approach in defining the disorder is unexpected and in many cases appears to be a disavowal of responsibility for certain kinds of problems. This is illustrated by definitions that provide notice that children who are truant, abuse drugs or alcohol, or who are delinquent are automatically excluded from the category. The category is defined not by the existence of a behavior disorder but rather by how this disorder is manifested and by what effects it has.

In the absence of eligibility guidelines generated at the state level these decisions have been relegated to local authority. Some have made extensive efforts to develop program entrance criteria. What are the important indicators that a child, because of a behavior disorder, needs special education? As might be expected, specific behaviors and the impact of these behaviors are frequently mentioned as program entrance criteria. Additionally, specific attempts to deal with a problem and the lack of success of these efforts are being used as diagnostic criteria. Using this

approach, if attempts to modify behavior fail it would seem to follow that the existence of a behavior disorder is confirmed. Such a notion will clearly be more affected by the resources available than the nature of the child's disorder. It would seem that exercising some caution would be in order when diagnostic criteria are so clearly external to the child. If efforts to identify behavior disordered children are ever to approach some level of validity, it will be necessary that diagnostic criteria be identified that are firmly supported by research and commonly held by practitioners in the field.

Some procedural requirements for identification and service provision are prescribed by the state (a specific case study evaluation and multidisciplinary staffing) and by federal regulation (a multifactored evaluation and multidisciplinary staffing). It is not clear that these procedures are fully in place throughout the state. Procedures for referral, evaluation and program placement vary considerably in published guidelines and most probably in practice as well. Much of the process appears to be subject to professional judgment and other informal procedures. Much of this has evolved over time and is idiosyncratic in nature. The population to be served cannot be reliably identified under these circumstances. Though considerable variety in professional practices will always exist and, to a reasonable extent, is welcomed, such wildly divergent procedures serve no useful purpose and most likely result in an ill-defined and ill-served group of handicapped children.

Fair and equal access to special education cannot be guaranteed in Illinois using the present set of variable definitions, diagnostic criteria and procedures. In addition to this broader concern, the analyses of practices confirm that many are inconsistent with the available research base and a number of commonly held "best practices." We know more about behavior disorders and how to identify them than is evidenced in the current situation. Kauffman (1982) has pointed out that meeting the to provide a free and appropriate education will be very difficult because identification procedures are subjective, inconsistent and can easily be avoided by school officials when they choose to do so. Appropriate protection of the educational rights of behavior disordered children cannot be guaranteed with the system in place. The only acceptable response to the data collected and reviewed is an effort to review and refine the definition of behavior disorders, clarify the parameters with clearly stated diagnostic criteria and identify appropriate referral, evaluation and placement procedures on a statewide basis.

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